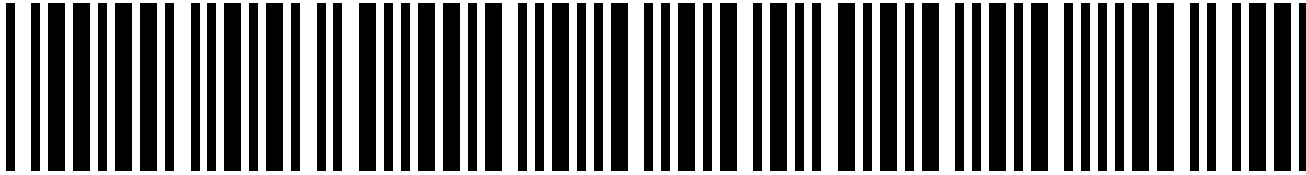


This packet is an example of the order in which documents should be filed. These are not examples of how to fill out forms/documents.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE
DOCUMENT COVER SHEET



Is this a new case? Yes ☒ No ☐ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☒

More than 15 Companion Cases ☐

9/10/2008

Date:(MM/DD/YYYY)

SSN: 000-00-0000

☐ Specific Injury

Case Number 1

☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 420

Body Part 3:

Body Part 2: 100

Body Part 4:

Other Body Parts:

Please check unit to be filed on (check only one box)

☐ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ VOC ☐ INT ☒ RSU

Companion Cases

☐ Specific Injury

Case Number 2 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

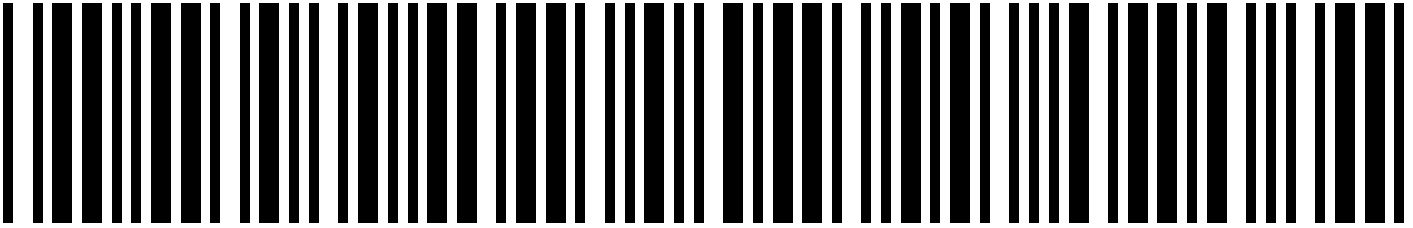
Body Part 3:

Body Part 2:

Body Part 4:

Other Body Parts:

DOCUMENT SEPARATOR SHEET



Product Delivery Unit RSU

Document Type DWC - AD FORMS

Document Title DWC-AD 10120 REQUEST FOR REIMBURSEMENT OF ACCOMMODATION EXPENSES

Document Date

MM/DD/YYYY

Date of document following
Document Separator Sheet

Author

UNIFORM ASSIGNED NAME

If you are the Claims Administrator or the
Hearing Representative use your Uniform
Assigned Name.
If you are the employer, "Author" is employer

Office Use Only

Received Date

MM/DD/YYYY

Request for Reimbursement of Accommodation Expenses
For injuries on or after July 1, 2004
Form DWC AD 10005

Name of Employer: _____ Address of Employer: _____

Phone Number: _____ Name of Injured Employee: _____

WCAB number (if applicable): _____ Claim Number _____

Job Title (at time of injury): _____

Job Duties (attach job description if available): _____

Date of Injury: _____

Reimbursement is requested for expenses to accommodate a:

_____ temporarily disabled employee (\$1250 maximum)

_____ permanently disabled employee (\$2500 maximum)

Employee's work restrictions and accommodation required (attach treating physician's, QME or AME report):

Itemized list of costs for which reimbursement is requested (attach all receipts):

1. Modification to worksite (list all work done and total cost) _____ Cost _____

2. Equipment, furniture and/or tools (list each item and cost) _____ Cost _____

3. Any other accommodation expenses: _____ Cost _____

(Attach additional sheets if necessary)

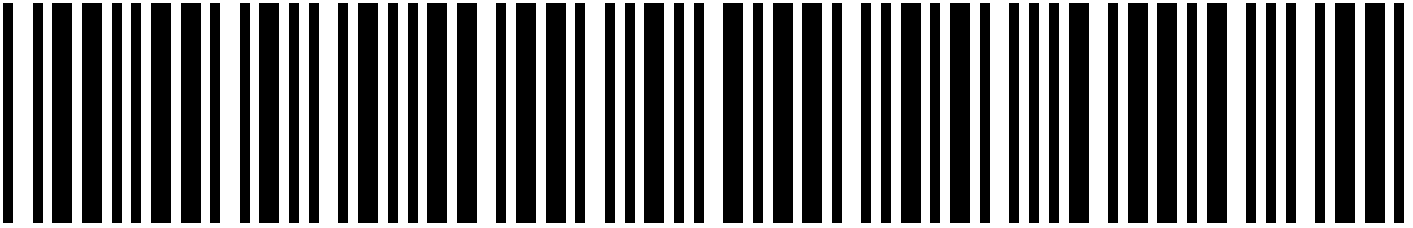
Total Costs: _____

The above costs have not been paid for and are not covered by the insurance carrier or any other source.

I declare that the information I have provided on this form is true and correct under penalty of perjury.

Signature of employer or employer's representative _____ Date _____

DOCUMENT SEPARATOR SHEET



Product Delivery Unit RSU

Document Type SUPPORTING DOCUMENTS

Document Title STD FORM 204 - PAYEE DATA RECORD

Date of document following
Document Separator Sheet

Document Date MM/DD/YYYY

If you are the Claims Administrator or the
Hearing Representative use your Uniform
Assigned Name.
If you are the employer, "Author" is employer

Author UNIFORM ASSIGNED NAME

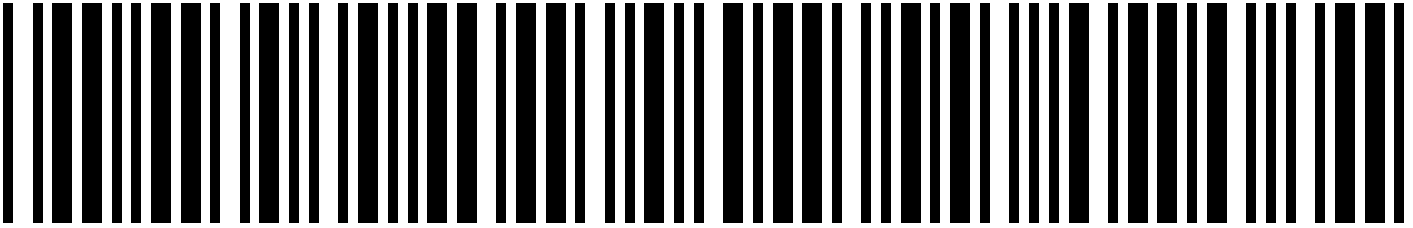
Office Use Only

Received Date MM/DD/YYYY

STD. 204 (Rev. 5-2003)

1	INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the State agency (department/office) address shown at the bottom of this page. Prompt return of this fully completed form will prevent delays when processing payments. Information provided in this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information and Privacy Statement. NOTE: Governmental entities, federal, State, and local (including school districts), are not required to submit this form.								
2	PAYEE'S LEGAL BUSINESS NAME (Type or Print) <table border="1"><tr><td>SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)</td><td>E-MAIL ADDRESS</td></tr><tr><td>MAILING ADDRESS</td><td>BUSINESS ADDRESS</td></tr><tr><td>CITY, STATE, ZIP CODE</td><td>CITY, STATE, ZIP CODE</td></tr></table>			SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)	E-MAIL ADDRESS	MAILING ADDRESS	BUSINESS ADDRESS	CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE
SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)	E-MAIL ADDRESS								
MAILING ADDRESS	BUSINESS ADDRESS								
CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE								
3	PAYEE ENTITY TYPE CHECK ONE BOX ONLY <table border="1"><tr><td><input type="checkbox"/> PARTNERSHIP</td><td><input type="checkbox"/> ESTATE OR TRUST</td><td><input type="checkbox"/> INDIVIDUAL OR SOLE PROPRIETOR</td></tr><tr><td colspan="3">ENTER SOCIAL SECURITY NUMBER: _____</td></tr></table> <small>(SSN required by authority of California Revenue and Tax Code Section 18646)</small>		<input type="checkbox"/> PARTNERSHIP	<input type="checkbox"/> ESTATE OR TRUST	<input type="checkbox"/> INDIVIDUAL OR SOLE PROPRIETOR	ENTER SOCIAL SECURITY NUMBER: _____			NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.
<input type="checkbox"/> PARTNERSHIP	<input type="checkbox"/> ESTATE OR TRUST	<input type="checkbox"/> INDIVIDUAL OR SOLE PROPRIETOR							
ENTER SOCIAL SECURITY NUMBER: _____									
4	<table border="1"><tr><td><input type="checkbox"/> California resident - Qualified to do business in California or maintains a permanent place of business in California.</td></tr><tr><td><input type="checkbox"/> California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State income tax withholding. <input type="checkbox"/> No services performed in California. <input type="checkbox"/> Copy of Franchise Tax Board waiver of State withholding attached.</td></tr></table>			<input type="checkbox"/> California resident - Qualified to do business in California or maintains a permanent place of business in California.	<input type="checkbox"/> California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State income tax withholding. <input type="checkbox"/> No services performed in California. <input type="checkbox"/> Copy of Franchise Tax Board waiver of State withholding attached.				
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5	<p>I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the State agency below.</p> <table border="1"><tr><td>AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)</td><td>TITLE</td></tr><tr><td>SIGNATURE</td><td>DATE</td><td>TELEPHONE ()</td></tr></table>			AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)	TITLE	SIGNATURE	DATE	TELEPHONE ()	
AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)	TITLE								
SIGNATURE	DATE	TELEPHONE ()							
6	Please return completed form to: Department/Office: _____ Unit/Section: _____ Mailing Address: _____ City/State/Zip: _____ Telephone: () _____ Fax: () _____ E-mail Address: _____								

DOCUMENT SEPARATOR SHEET



Product Delivery Unit RSU

Document Type SUPPORTING DOCUMENTS

Document Title MEDICAL REPORT

Document Date 02/05/2008
MM/DD/YYYY

Author JOHN A SMITH MD

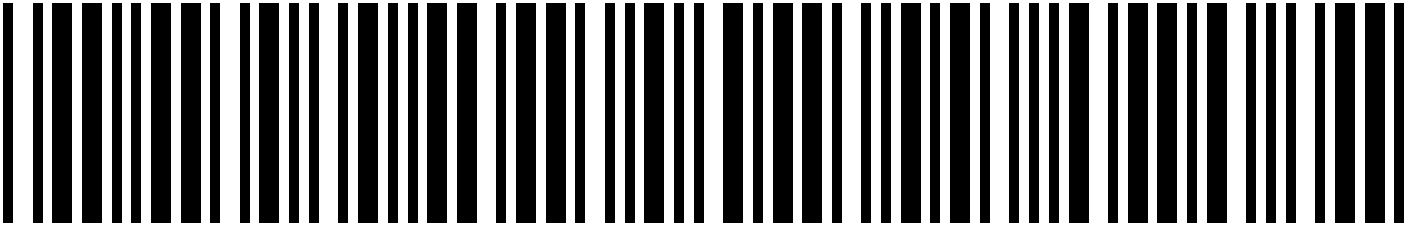
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Received Date _____
MM/DD/YYYY

DR. JOHN A. SMITH MEDICAL REPORT
Containing work restrictions being accommodated

REPORT DATED February 5, 2008

DOCUMENT SEPARATOR SHEET



Product Delivery Unit RSU

Document Type SUPPORTING DOCUMENTS

Document Title JOB DESCRIPTION

Document Date 06/05/2008
MM/DD/YYYY

If you are the Claims Administrator or the
Hearing Representative use your Uniform
Assigned Name.
If you are the employer, "Author" is employer

Author UNIFORM ASSIGNED NAME

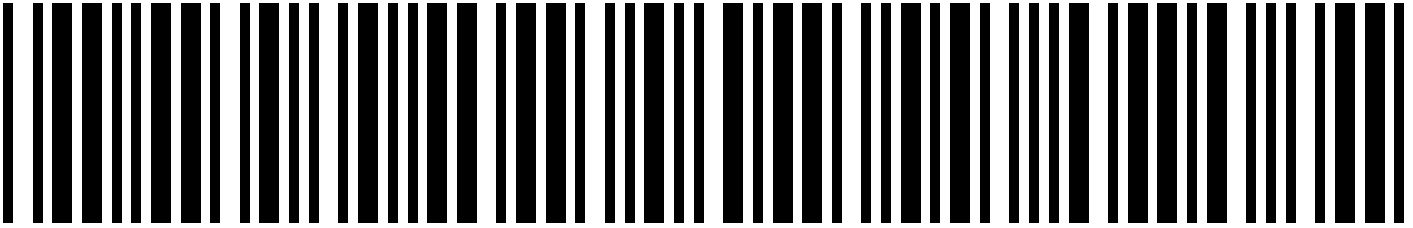
Office Use Only

Received Date _____
MM/DD/YYYY

OTHER SUPPORTING DOCUMENTS

DATED June 5, 2008

DOCUMENT SEPARATOR SHEET



Product Delivery Unit RSU

Document Type SUPPORTING DOCUMENTS

Document Title EQUIPMENT AND MODIFICATION INVOICES

Document Date 04/05/2008
MM/DD/YYYY

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Hearing Representative use your Uniform
Assigned Name.
If you are the employer, "Author" is employer

Author UNIFORM ASSIGNED NAME

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Received Date _____
MM/DD/YYYY



ALL RECEIPTS FOR ACCOMODATION EXPENSES

DATED April 5, 2008